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SECTION: CAPITOL HILL HEARING TESTIMONY

HEADLINE: TESTIMONY May 11, 1995 WITNESS LIST SENATE APPROPRIATIONS INTERIOR AND RELATED AGENCIES FY96 INTERIOR APPROPRIATIONS

BODY:

DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE

INDIAN HEALTH SERVICE

WITNESSES

Principal Witness:

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Accompanied by:

Michel E. Lincoln, Deputy Director

Phillip L Smith, M.D., Associate Director, Office of Health

Programs

Gary J. Hartz, Acting Associate Director, office of

Environmental Health and Engineering

Reuben T. Howard, Acting Director, Office of Tribal Self-

Governance

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CAPITOL HILL HEARING TESTIMONY

HEADLINE: TESTIMONY May 11, 1995 MICHAEL H. TRUJILLO, MD ASSISTANT SURGEON GENERAL INDIAN HEALTH SERVICE SENATE APPROPRIATIONS INTERIOR AND RELATED AGENCIES FY96 INTERIOR APPROPRIATIONS

BODY:

`DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

MICHAEL H. TRUJILLO, M.D. M.P.H

ASSISTANT SURGEON GENERAL, DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

INTERIOR SUBCOMMITTEE

OF THE

SENATE APPROPRIATIONS COMMITTEE

HEARING ON FY 1996 BUDGET REQUEST

MAY 11, 1995

Mr. Chairman and Members of the Committee:

I am Dr. Michael H. Trujillo from the Laguna Pueblo, New Mexico. I am the Director of the Indian Health Service (IHS) .Accompanying me today are Mr. Michel E. Lincoln, Deputy Director; Mr. Reuben To Howard, Acting Director, Office of Tribal Self-Governance; Dr. Phillip L. Smith, Associate Director, Office of Health Programs; and Mr. Gary J. Hartz, Acting Associate Director, Office of Environmental Health and Engineering. Representing the Office of the Secretary is Mr. Dennis Williams, Deputy Assistant Secretary for Budget. We are pleased to be here to discuss the fiscal year (FY) 1996 budget request for the IHS.

I began my career as a primary care physician at an IHS facility near the reservation where I grew up in New Mexico. My directorship of this Agency began one year ago. My appointment on March 28, 1994, followed unanimous confirmation by the Senate. I was sworn in as Director on April 8, 1994, by Dr. Philip Lee,

Assistant Secretary for Health and moved to Maryland in June. This year I have begun to prepare this Agency to enter a new era of health care delivery and to strengthen the partnership with tribes in determining how those services will be delivered.

Providing health care to Indian people is an honor and distinct privilege. The Agency has been fortunate to have employees who are dedicated to the key mission of the Agency: that is to raise the health status of American Indians and Alaska Natives (AI/ANs) to the highest possible level. Three employees who exemplified this dedication and commitment were Dr. Christopher Krogh, Dr. Ruggles Stahn, and Dr. Arvo Oopik. All three physicians lost their lives last year while delivering health care to rural areas in the Dakotas. This year we are dedicating our health care efforts in their memory.

The IHS, unlike any other Federal agency, is committed to carrying out the Federal responsibility of providing high quality health services to AI/ANs. Numerous treaties, statutes, and executive orders have established and confirmed this Federal responsibility. During the 1970s, two historic legislative bills, the American Indian Health Care Improvement Act and the Indian Self Determination and Education Assistance Act, were passed by the Congress and enthusiastically endorsed by the President. These bills fundamentally effected and clearly established the IHS mission and goals and clarified the commitment and responsibilities of the Federal government with regard to: 1) Indian self-determination based on the special and unique relationship that exists between the Federal government and tribal governments and 2) Indian health by committing to raise the health status of AI/ANs to the highest possible level.

President Clinton reaffirmed the government-to-government relationship in a meeting with Indian leaders at the White House last April. The President directed Federal agencies to consult with tribal governments on any action affecting Indian people. His directive re-enforces the intent of the Congress when it passed the Indian Self-Determination Act in 1976. This legislation is a cornerstone of Federal/Tribal relations and reaffirms the government-to-government relationship between the United States and Indian Nations.

Under the long-standing Federal policy of Indian Self- Determination, the IHS must support the right of all tribes to decide whether they want to compact, contract or retain Federally delivered health care services for their communities. The IHS is obligated to ensuring that it can carry out its responsibilities to all tribes regardless of the avenue of tribal self-determination selected by the tribes.

The Congress has continued to refine and expand opportunities for tribes and Indian communities to deliver health care to their own people. The number of tribes and urban Indian organizations assuming the responsibility of delivering health services has steadily increased and has now reached an unprecedented level: one-third of the Agency's annual appropriation is invested in the delivery of health services by tribal governments. The balance of those appropriations are utilized by the IHS to provide direct services to sovereign Indian Nations that also exercise their right to self-determination by choosing to have the Federal government provide those health services and by urban Indian health organizations pursuant to Title of the Indian Health Care Improvement Act.

The IHS, like other health care providers, is facing ever increasing costs in delivering health care. The IHS provides services to approximately 1.4 million AI/ANS residing in urban, remote, rural and isolated areas in 34 states. The cost of providing care in urban areas {where there is a health care infrastructure) is significant, but less than the cost of providing care in rural and isolated areas where there is no infrastructure.

The IHS service population is unique. Tribal culture, family, traditions, religion, and values that are passed from generation to generation dictate the need for specialized methods of delivering appropriate health care in a variety of settings. The many diverse AI/ANs cultures have survived and co-exists within a dominant society that has sometimes aggressively tried to alter or even destroy it. The fact of our survival and existence requires and deserves culturally sensitive program delivery.

The partnership of the Congress, tribal governments, Indian organizations, and the IHS has resulted in significant improvements in the health status of Indian people. For example, the age-adjusted death rate among AI/ANs because of gastrointestinal diseases declined by 81 percent since 1973. This success is due to the IHS sanitation facilities construction program. The age-adjusted death rate of tuberculosis has declined by 74 percent for the same period. This success is related to extensive IHS, tribal, public health and community outreach programs. The maternal death rate has declined by 65 percent for the same period because of IHS maternal and child health programs. The age-adjusted death rate because of accidents declined by 54 percent, a success related to innovative tribal and IHS injury prevention programs. The IHS has achieved immunization rates of 93 percent for 2-year old Indian children. This rate exceeds the average of 67 percent for all races within the U.S. population.

These accomplishments prove that working in partnership with local Indian communities does work. They also prove that providing the full continuum of care including public health, prevention, and acute care pays dividends in improved health status, and that community outreach programs designed to encourage individuals to be responsible for his or her own health can succeed. However, there still remains a large gap between the health status of AI/ANs and the health status of the rest of society. All of us together must close that gap.

Like the rest of the nation's health care systems, the IHS must manage in an environment of increasing health care costs, and a growing service population. It is, therefore, imperative that the IHS manage its resources efficiently. Recently, I articulated my vision for a new IHS to the stakeholders in Indian health. My vision includes designing an organization that will have fewer layers of management, while directing resources to the local community. I recognize that operations must become more efficient commensurate with changes in laws, regulations, and technology. Fewer layers of management will reduce the overhead functions of the Agency, and, as a result, we're looking at ways to improve services to our customers by transferring positions and staff to local programs.

The IHS is changing, but this change must be undertaken through partnership with the more than 500 Indian Nations. To initiate the process of change, I embarked upon discussions with IHS customers and employees in October of last

year. I convened a customer-dominated group to design a new IHS that will result in improved delivery of services. The group is the Indian Health Design Team and it will guide the process of change. The process will have the active participation of tribal leaders, IHS customers and employees, and health care professionals. This process reaffirms the sovereignty of Indian nations and the right of Indian people to quality health care throughout the United States.

The call for changes in the IHS is not only coming from the Administration and the Congress, but from tribal governments as well. For example, in response to tribal leaders' desire for more control of its programs and resources, the Congress amended the Indian Self- Determination Act last year to require IHS to compact with up to 30 additional tribes each year so they can provide their own health care based upon their own priorities and design. Depending on the availability of funding, more tribes are expected to assume their share of the Federal responsibility for their health care. Under this self-governance demonstration authority, IHS must reduce its administrative costs and transfer those functions and funds to those compacting tribes.

In the coming year, we will emphasize programs in elder care, youth substance abuse prevention, child abuse prevention, and women's health. We must continue to maintain our accomplishments in elevating the health status of Indian people. With the partnership between the IHS, tribes, Indian organizations, and the support of the Congress, we will strive to be the best community oriented primary care delivery system in the country.

The President's budget requests a program level of $2.3 billion, including $2 billion for health services and $247 million for health facilities. The 4.5 percent increase over FY 1995 includes increases of $9.1.3 million to allow for the continuation of the FY 1995 program levels in FY 1996; $10.8 million to staff and operate newly constructed facilities; $10.5 million for program expansion in Information System Initiatives, Women and Elder Health, Epidemiology Centers, Child Abuse, Contract Health Services, Urban Health and the Indian Self-Determination Fund. The request includes $11.2 million to complete the construction of the Hays, Montana and White Earth, Minnesota Health Centers.

The Indian Health Service is committed to current efforts to streamline and reinvent the Federal government. Participating in this important initiative will, without a doubt, affect our resources and, ultimately, the delivery of health care. If the IHS' applied expertise in core public health functions critical to elevating the health status of AI/AN is diminished, the progress achieved in reducing the disparity in health status will be lost. The challenge before all of us -IHS, Tribes, Congress -is to design a more efficient and effective IHS so that we do not lose momentum in our fight to improve the health of AI/ANs. We are prepared, and indeed have begun, to take on this challenge. However, it is important to remember that we are dealing with sovereign nations. The ramifications of any change in the delivery of Federal services to these populations requires extensive consultation and involvement with these sovereign governments.

Mr. Chairman, this concludes my statement. We will be pleased to answer any questions that you may have. Thank you.

Michael H. Trujillo, M.D., M.P.H.

Director

Indian Health Service

Michael H. Trujillo, M.D., M.PH., is the first Presidential appointed to head the Indian Health Service (IRS), an agency of the U.S. Public Health Service (PHS) .

He was formally sworn in as director of the IHS on April 9, 1994. He was nominated by President Clinton Nov. 22, 1993, and confirmed by the Senate March 25, 1994. Dr. Trujillo is the second American Indian to head the Agency and the first full-blooded Indian to do so.

As IHS director, Dr. Trujillo directs a $1.9 billion national health care delivery program responsible for providing preventive, curative, and community care for approximately 1.3 million of the nation's 2 million American Indians and Alaska Natives. As the director he is an Assistant Surgeon General and holds the rank of Rear Admiral in the Commissioned Corps of the PHS.

As a full-blooded American Indian, Dr. Trujillo's roots are from his reservation, the Laguna Pueblo, New Mexico, and as a physician his home has been the PHS. Dr. Trujillo has dedicated his career to strengthening the health care delivery system for American Indians and Alaska Natives and improving the health status of Indian communities nationwide. He advocates for the involvement of Tribal representatives in managing their own health care programs through self-determination and self-governance programs.

Dr Trujillo was raised at Laguna Pueblo, where his parents were teachers at the Bureau of Indian Affairs grade school. He was the first American Indian to graduate from the University of New Mexico School of Medicine, and the 53rd American Indian doctor in the country. Dr. Trujillo's commitment to improving the quality of life for American Indians follows the example set by his father, Miguel H. Trujillo, who was instrumental in obtaining the right to vote for New Mexico Indians in 1949.

His assignment before his appointment was as the chief medical officer for the Portland, Ore., area of the IHS. Dr. Trujillo managed direct and preventive health delivery programs serving 120,000 American Indian residents on 40 reservations and urban areas in a three-state region. He led a team effort to implement managed care programs and Total Quality Management initiatives for all service units of the Portland Area and health programs owned and operated by various tribes. Previously, Dr. Trujillo was a Clinical Specialty Consultant to the Bemidji, MN., area of the IRS, where he helped coordinate a three-state regional chronic disease program.

He served concurrently as the associate warden for medical and hospital program and as the medical director at the Federal Medical Center of the Bureau of Prisons in Rochester, Minn. He directed the medical and hospital staff, and also practiced as an interest for a new medical, surgical, and psychiatric national referral center of the Bureau of Prisons. He also coordinated specialty medical services with the Mayo Clinic, also in Rochester. The Federal Medical Center became the major center within the Bureau of Prisons for prisoners with complex diseases, including AIDS and IHV.

Dr. Trujillo has also served as deputy area director and as the area chief medical officer for the Aberdeen, S.D, area of the IHS. He managed a direct health care delivery program for a four-state region serving 70,000 American Indians in 16 tribes.

Throughout his professional career in the PHS, Dr. Trujillo has held various senior level management positions including the PHS Regional Office in New York City and the Phoenix, Ariz., IRS Area Office working with diverse local cultures. On a special assignment to work with the American Indian Health Care Association in St. Paul, MN., he was a special projects officer responsible for initiating nationwide quality assurance programs and a medical provider recruitment program for urban Indian health centers.

Dr Trujillo received his undergraduate, graduate, and medical degrees from the University of New Mexico, Albuquerque. Ms medical training is in family practice and internal medicine, and includes a clinical fellowship in preventive medicine at the Mayo Clinic. He received a masters degree in public health administration and policy from the University of Minnesota School of Public Health.

Dr. Trujillo's professional affiliations have allowed him to serve as a health advocate for Indian people. He is a member of the American College of Physician Executives, the American Association of Indian Physicians, the Association of Military Surgeons of the U.S., the National Rural Health Care Association, the Western Canadian/American Health Council, and the American Public Health Association. Among other committees, he serves on the Total Quality Management Executive Council for the Portland IHS Area, the National IHS Managed Care Committee, and on the Advisory Committee of the Native American Center for Excellence at the School of Medicine of the University of Washington, Seattle.

Dr. Trujillo and his wife Judith have three young daughters.